Hoosier CARE CONNECT Frequently Asked Questions

Contents

Overview of Program

Q1. What is Hoosier Care Connect?

A. Hoosier Care Connect is a new coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare. Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s). Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services. Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.

Q2. What is a managed care entity (MCE)?

A. An MCE is a health plan that contracts with the Indiana Family and Social Services Administration (FSSA) to deliver covered services to Hoosier Care Connect enrollees. MCEs will receive a per-member, per-month payment and will be at financial risk for all services included in the contract. The MCE will develop a network of physicians and other providers who provide healthcare services to members and reimburse claims for services rendered. Through FSSA's contract, MCEs are held accountable for achieving metrics related to outcomes, process, quality and satisfaction and are given financial incentives tied to achievement of performance metrics.

Q3. What MCEs will FSSA contract with for Hoosier Care Connect?

A. The State has awarded contracts to Anthem, Managed Health Services (MHS) and MDwise. These MCEs were chosen through a fair and open procurement process managed by the Indiana Department of Administration and FSSA. MCEs were chosen based on their responses to a Request for Proposals (RFP) posted in the summer of 2014. Prospective vendors were assessed based on many factors, including their experience serving complex populations and approaches to care management.

Q4. What are the goals of Hoosier Care Connect?

A. In developing Hoosier Care Connect, FSSA seeks to achieve the following goals:

- Improve quality outcomes and consistency of care across the delivery system
- Ensure enrollee choice, protections and access
- Coordinate care across the delivery system and care continuum
- Provide flexible person-centered care

Q5. Why is the State implementing Hoosier Care Connect?

A. IHCP's aged, blind, and disabled members are currently served under a fee-for-service model. In general, current strategies do not tie service delivery to quality measures or clinical outcomes. Additionally, there is a lack of integration and care coordination among service delivery providers

and no overarching entity or provider responsible for outcomes across the healthcare delivery system. Hoosier Care Connect seeks to address these shortcomings. Anticipated outcomes include:

- Improved care coordination across the healthcare delivery system
- Promotion of preventive and holistic care addressing physical, behavioral, medical and social needs
- Increased consumer engagement in the management and treatment of member conditions
- Improved quality of care and health outcomes

Q6. How did the State go about designing the Hoosier Care Connect program?

A. House Enrolled Act 1328 (HEA 1328) passed by the Indiana General Assembly in 2013 tasked FSSA with submission of a report to the Health Finance Committee regarding options for managing care for Indiana Medicaid's aged, blind and disabled population. In response to HEA 1328, FSSA convened the Aged, Blind and Disabled Task Force (Task Force). The Task Force undertook a comprehensive analysis of current Indiana Medicaid enrollment, expenditures and programming. Additionally, it reviewed nationwide trends and Medicaid managed care strategies available for disabled populations. Throughout this process, stakeholder feedback was garnered through a variety of strategies. Stakeholders were invited to provide proposals or ideas to the Task Force. Additionally, a stakeholder survey was developed and distributed with a total of 143 surveys returned representing providers, consumers, advocates and other stakeholders. The process undertaken by the Task Force, lessons learned, and goals garnered through stakeholder feedback, laid the foundation for development of the Hoosier Care Connect program.

Eligibility Criteria & Covered Benefits

Q7. Who is eligible for Hoosier Care Connect?

A. Hoosier Care Connect is for IHCP members age 65 and over, or with blindness or a disability who are residing in the community. Individuals enrolled in Medicare, and those residing in an institution or receiving services through a home and community-based services (HCBS) waiver, will not be eligible for Hoosier Care Connect. Individuals in the following eligibility categories who do not have an institutional level of care and are not enrolled in Medicare will be enrolled in Hoosier Care Connect:

- Aged individuals
- Blind individuals
- Disabled individuals
- Individuals receiving Supplemental Security Income
- M.E.D. Works enrollees

Children who are wards of the State, receiving adoption assistance, foster children and former foster children may also voluntarily enroll in the program.

Q8. How many people will be covered under Hoosier Care Connect?

A. FSSA anticipates enrollment of approximately 84,000 individuals in the first year of the program.

Q9. What benefits are covered under Hoosier Care Connect?

A. Hoosier Care Connect enrollees will receive all Medicaid-covered benefits in addition to care coordination services and other enhanced benefits developed by MCEs, with approval from FSSA. Hoosier Care Connect MCEs will be responsible for the majority of covered services including primary care, acute care, prescription drugs and certain over-the-counter drugs, behavioral health, emergency services, dental and transportation. MCEs will not be financially responsible for some services, referred to as "carve-outs." The Hoosier Care Connect carve-outs include Medicaid Rehabilitation Option (MRO) services, 1915(i) State Plan home and community-based services, and FirstSteps and individualized education plan services. While MCEs are not financially responsible for carved-out services, they must ensure coordination of all Medicaid-covered services and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

Q10. What members are excluded from Hoosier Care Connect?

A. Individuals will be removed from the Hoosier Care Connect program and transitioned to fee-for-service if they enter a nursing home for a stay longer than 30 days, state psychiatric facility, psychiatric residential treatment facility (PRTF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID), begin receiving hospice benefits in an institutional setting, or become eligible for an HCBS waiver or Medicare.

<u>Implementation Plan</u>

Q11. When will individuals be eligible to enroll in Hoosier Care Connect?

A. The member enrollment implementation process has been designed to optimize member choice. Current IHCP members eligible for Hoosier Care Connect will begin receiving notices informing them of the program and how to enroll beginning in February 2015. The enrollment broker will also attempt to contact impacted members via telephone. Members will have until June 15, 2015 to make an MCE selection. If no selection is made by this date, members will be auto-assigned to an MCE.

The first MCE assignments will be effective April 1, 2015 for members who make a selection by March 25, 2015. Enrollments will continue to be effective the 1st and 15th of every month based on when a member makes an MCE selection.

Foster children, children receiving adoption assistance and former foster children will be eligible for the program beginning May 1, 2015.

Q12. Will *Care Select* continue to operate?

A. As Hoosier Care Connect is implemented the current *Care Select* program will expire. Hoosier Care Connect and *Care Select* will operate concurrently from April 1, 2015 through June 30, 2015 to optimize member choice and ensure continuity of care. No new *Care Select* assignments will be

made. However, members who are currently enrolled in *Care Select* will remain enrolled with their care management organization until they select a Hoosier Care Connect MCE. *Care Select* will no longer operate as of July 1, 2015. Any remaining *Care Select* members who have not made an MCE selection by June 15, 2015 will be auto-assigned to a Hoosier Care Connect MCE.

Q13. What information will be made available to IHCP members to assist them in making an MCE selection?

A. The Enrollment Broker serves as a neutral third party to assist members in making an MCE selection for Hoosier Care Connect. The Enrollment Broker provides information on the healthcare providers available in each MCE's network and any enhanced benefits and programs being offered by each MCE that may be of interest to the member.

Provider Questions

Q14. What action is needed by Indiana Health Coverage Program (IHCP) providers?

A. FSSA strongly encourages providers to consider joining an MCE network. Once MCEs have demonstrated they have a sufficient number of providers to serve their members they will be permitted to require members to utilize in-network providers.

Providers may participate in more than one MCE network. Please contact the Hoosier Care Connect MCEs as described below to learn more about joining the network.

MCE	Contact
Anthem	Esther Cervantes Provider Relations (812) 202-3838 estherling.cervantes@anthem.com
MHS	John Yates Vice President, Contracting and Network (317) 684-9478 jyates@mhsindiana.com
MDwise	Marc Baker Director of Provider Relations (317) 822-7390 mbaker@mdwise.org

Q15. What is the deadline to become a Hoosier Care Connect provider?

A. There is not a specific deadline to become a Hoosier Care Connect provider. However, eligible members will begin making MCE selections in February 2015. MCE selection is often based on a member's established relationship with a healthcare provider. Therefore, providers are strongly encouraged to consider joining an MCE as soon as possible. Effective July 1, 2015, once MCEs have

demonstrated network adequacy, they will be permitted to require members to utilize in-network providers.

Q16. How do providers verify that a patient is enrolled in Hoosier Care Connect?

A. MCEs will be issuing ID cards for their enrolled members. IHCP recipient identification numbers (RID) for IHCP members transitioning to Hoosier Care Connect will not change. Providers should continue to verify member eligibility using existing IHCP Eligibility Verification Systems (EVS). EVS will identify the following information:

- The member is eligible for Hoosier Care Connect
- The member's primary medical provider (PMP)
    - Until a member has selected a PMP or been assigned to one, this field will display "PMP not available"
- The member's assigned MCE and the corresponding MCE contact information

Q17. *Care Select* covers PMP care conferences; will Hoosier Care Connect also provide reimbursement for this service?

A. Hoosier Care Connect includes reimbursement for PMP care conferences. MCEs will coordinate with Hoosier Care Connect PMPs to perform care coordination conferences to review a member's progress and care management plan. PMPs are eligible to be reimbursed for these care conference services. PMPs should refer to the member's MCEs for billing instructions.

Q18. What do providers need to do to ensure continuity of care for patients that have a current prior authorization in place?

A. As members transition to Hoosier Care Connect, all approved prior authorizations (PAs) will be honored by Hoosier Care Connect MCEs for 90 calendar days or until the authorization expires. No action will be needed by providers for members to have authorization for previously approved services. After the transitioned PAs expire providers must request future PAs from the member's MCE.

Q19. If a provider is not enrolled in a patient's Hoosier Care Connect MCE network can the provider treat the member and get reimbursed?

A. During the first 90 days of Hoosier Care Connect operations, MCEs are required to allow members who are receiving services from an out-of-network provider to continue receiving services from that provider and to reimburse accordingly. Beginning July 1, 2015, MCEs that have demonstrated network adequacy will be permitted to require members to utilize in-network providers. Once an MCE's network is established, the MCE may require providers to participate in their network to be reimbursed, unless the MCE is unable to provide medically necessary services from an in-network provider. Additionally, reimbursement for the following self-referral services will be paid to out-of-network providers who are enrolled in the IHCP:

- Chiropractic services
- Diabetes self-management services

- Emergency services
- Family planning services
- Immunizations
- Podiatry
- Psychiatric services
- Vision

Q20. Will the MCEs develop their own preferred drug lists (PDL)?

A. MCEs will develop their own preferred drug lists (PDL) which will be available from each MCE and posted on their websites once final State approval of the PDL has been obtained.

Q21. Are there any covered services providers will not bill to the Hoosier Care Connect MCEs?

A. MCEs will not reimburse claims for Medicaid Rehabilitation Option (MRO) services, 1915(i) State Plan home and community-based services, and FirstSteps and individualized education plan services. Providers will continue to bill the IHCP instead of the MCEs for these carved-out services.

Member Questions

Q22. Can I apply for Hoosier Care Connect? How do I apply?

A. You do not specifically apply for Hoosier Care Connect. You apply for Medicaid and if you are determined to be eligible and are aged, blind or disabled, don't reside in an institution, do not receive Medicare, and are not eligible for home and community-based services (HCBS) waiver services, you will be eligible for Hoosier Care Connect. You will receive a letter from the Indiana Family and Social Services Administration (FSSA) telling you if you are eligible for Hoosier Care Connect.

Q23. What is different between Hoosier Care Connect and Traditional Medicaid?

A. In Hoosier Care Connect you enroll with a health plan that provides most of your Medicaid-covered benefits. A health plan, also called a managed care entity (MCE), is a group of doctors, pharmacies and hospitals that work together to help you get the health services you need. You can choose one of the following three health plans: Anthem, MHS or MDwise. All plans offer the same services but may work with different doctors or hospitals and may offer special programs that you would like. Your health plan will also offer special services such as a 24-hour nurse helpline and care coordination services based on your needs.

Q24. If I am already enrolled in Medicaid, will I lose any services when I move to Hoosier Care Connect?

A. You will still receive full Medicaid benefits as a member of Hoosier Care Connect. Hoosier Care Connect only changes how you get your medical care. You will also receive care coordination services based on your needs.

Q25. I already receive case management services through my community mental health center. Will I lose these services when I move to Hoosier Care Connect?

A. You will not lose any case management services you are currently receiving through your community mental health center. Your health plan will work with your current case managers.

Q26. Can I go to any doctor as long as they accept Hoosier Care Connect or Medicaid?

A. Once you are enrolled with a health plan you will choose a primary medical provider (PMP). Your health plan will contact you to tell you what you need to do to select a PMP. Once you have selected a PMP you will see that doctor for most of your healthcare services. Your PMP will help you access other doctors that you need for any special healthcare needs you have. You can get the following healthcare services without a referral from your health plan or PMP:

- Behavioral health services
- Chiropractic services
- Diabetes self-management services
- Emergency services
- Family planning services
- Immunizations
- Podiatry
- Psychiatric services
- Vision

Q27. Can I change my primary medical provider (PMP) after I choose one?

A. You can change your PMP by calling your health plan.

Q28. What should I consider when choosing a health plan?

A. Choosing a health plan is a personal decision. While FSSA is confident that all health plans are able to meet your needs, you may want to consider the following points when choosing a health plan:

- *Doctor:* If you already have a favorite doctor that you want to continue to see, you should find out which plans he or she participates in. You can call the Hoosier Care Connect Helpline at 1-866-963-7383 to find out if your doctor participates in any of the health plans.

- *Locations:* You may want to make sure that the health plan has providers that are conveniently located for you. This may mean they are near your home, your work, your child's school, or on

a bus line. You can call the Hoosier Care Connect Helpline at 1-866-963-7383 to find out what doctors are located near you in each health plan.

- *Special Programs:* Hoosier Care Connect health plans each offer special programs such as disease management and wellness programs. You may want to select the health plan that offers special programs for something that is of interest to you. You can call the Hoosier Care Connect Helpline at 1-866-963-7383 to learn more about the special programs offered by each health plan.

Q29. How do I select a health plan?

A. To make your health plan selection, please call the Hoosier Care Connect Helpline at 1-866-963-7383.

Q30. When will my health plan selection become effective?

A. If you are already in enrolled in Medicaid and are moving into Hoosier Care Connect you will be notified. If you make a selection by March 25, 2015, your health plan selection will be effective April 1, 2015. Assignments to health plans are effective the 1st and 15th of each month. The cut-off date for an assignment to be effective the 1st of a month is the 25th of the previous month. The cut-off date for an assignment to be effective the 15th of the month is the 10th of the month. For example:

1. If you choose a health plan by April 10, 2015, you will be assigned on April 15, 2015
2. If you choose a health plan by April 25, 2015, you will be assigned on May 1, 2015

For new Medicaid enrollees, MCE selection can be made at the time of application. You are strongly encouraged to select your MCE when applying, however if you do not, you have sixty days from your eligibility date to do so.

Q31. What happens if I don't choose a health plan?

A. If you are already enrolled in Medicaid and don't choose a health plan by June 15, 2015, you will be assigned to one. If you are new to Medicaid and do not choose a health plan within sixty days of enrollment, you will be assigned one. It is better if you choose an MCE so you can go to a doctor's office that you know and who knows your history. Please contact the Hoosier Care Connect Helpline at 1-866-963-7383 to make your selection.

Q32. Can I change health plans after I make a selection?

You can change your health plan at certain times during the year:

- Any time during your first 90 days with a new health plan.
- Annually during your open enrollment period.

- If you file a grievance with your health plan, and the State finds that you have a good reason to change health plans. Another name for a good reason to change health plans is "just cause." You must first contact your health plan so they can attempt to resolve your concern. If you are still unhappy after contacting your health plan, you can call the Hoosier Care Connect Helpline at 1-866-963-7383, and they will review your request.
- If your primary medical provider (PMP) changes health plans, you can follow your PMP to the new health plan.

Q33. What can I expect after I choose a health plan?

A. You will receive an enrollment packet from your health plan after you make your selection. This enrollment packet will include a member identification card that you should carry with you at all times. You must show the member identification card to your doctor, hospital and pharmacy whenever you get services. The enrollment packet will also give you more information about Hoosier Care Connect, your health plan and how to access services.

Your health plan will also do a health screening to learn about any special healthcare needs you may have. It is very important you complete the health screening so you can receive special services based on your needs.

Q34. Some healthcare services I am currently receiving require prior authorization, meaning they have to be approved by Medicaid. What do I need to do to continue receiving these services?

A. If you are receiving a healthcare service that was previously authorized by Medicaid your Hoosier Care Connect health plan must continue to authorize that service for 90 calendar days or until the authorization ends. You do not need to do anything. When the authorization expires your healthcare provider must request new authorizations from your health plan.

Q35. Are there any reasons I would be removed from Hoosier Care Connect?

A. You will transition to Traditional Medicaid if you enter a nursing home for longer than 30 days, or enter a state psychiatric facility, psychiatric residential treatment facility (PRTF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID). You will also be transitioned to another Medicaid program if you begin receiving hospice benefits in an institutional setting, become eligible for home and community-based services through a Medicaid waiver program or enroll in Medicare.

Q36. What if I disagree with a decision made by my health plan?

A. If you disagree with a decision made by your Hoosier Care Connect health plan you can file an appeal with them. If you are not satisfied with the outcome of that appeal you can file an appeal with the State. You will receive a written notice from your health plan with instructions on how to appeal anytime they make a decision about your care or benefits. The member handbook you receive from your health plan will also give you instructions on how to file an appeal.

Q37. I am on M.E.D. Works – will I still have to pay my premiums when I enroll in Hoosier Care Connect?

A. Individuals on M.E.D. Works who enroll in Hoosier Care Connect will continue to pay premiums as they do today.